

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040022</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>California Gardens N & R</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>2829 S California</u> <u>Chicago</u> <u>60608</u> <div style="display: flex; justify-content: space-between;"> Number City Zip Code </div>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(773) 847-8061</u> Fax # <u>(773) 847-1603</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																									
IDPA ID Number: <u>363961687001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>07/01/94</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>																											

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number California Gardens N & R# 0040022 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>293</u>	Skilled (SNF)	<u>293</u>	<u>106,945</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>293</u>	TOTALS	<u>293</u>	<u>106,945</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>87,016</u>	<u>3,004</u>	<u>5,621</u>	<u>95,641</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>87,016</u>	<u>3,004</u>	<u>5,621</u>	<u>95,641</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.43%

D. How many bed-hold days during this year were paid by Public Aid?

129 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 7/1/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 7/1/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 38 and days of care provided 2,791Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number California Gardens N & R

0040022

Report Period Beginning: 01/01/03

Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	337,571	61,100	11,640	410,311		410,311		410,311			1
2	Food Purchase		426,478		426,478	(1,621)	424,857	(134)	424,724			2
3	Housekeeping		45,441	379,649	425,090		425,090		425,090			3
4	Laundry		23,402		23,402		23,402		23,402			4
5	Heat and Other Utilities			222,931	222,931		222,931	491	223,422			5
6	Maintenance	148,870	36,029	90,130	275,029		275,029	280	275,309			6
7	Other (specify):*							(41)	(41)			7
8	TOTAL General Services	486,441	592,450	704,350	1,783,241	(1,621)	1,781,620	596	1,782,217			8
	B. Health Care and Programs											
9	Medical Director			33,300	33,300		33,300		33,300			9
10	Nursing and Medical Records	2,745,727	222,603	9,841	2,978,171		2,978,171	(68,834)	2,909,337			10
10a	Therapy	54,709		16,698	71,407		71,407		71,407			10a
11	Activities	101,476	5,165	3,193	109,834		109,834		109,834			11
12	Social Services	81,806		2,858	84,664		84,664		84,664			12
13	Nurse Aide Training	3,895		1,555	5,450		5,450		5,450			13
14	Program Transportation			2,089	2,089		2,089	3	2,092			14
15	Other (specify):*							26	26			15
16	TOTAL Health Care and Programs	2,987,613	227,768	69,534	3,284,915		3,284,915	(68,805)	3,216,110			16
	C. General Administration											
17	Administrative	223,367		608,156	831,523		831,523	(504,830)	326,693			17
18	Directors Fees											18
19	Professional Services			79,410	79,410		79,410	(2,028)	77,382			19
20	Dues, Fees, Subscriptions & Promotions			57,763	57,763		57,763	(32,263)	25,500			20
21	Clerical & General Office Expenses	129,664	37,927	203,267	370,858		370,858	27,385	398,243			21
22	Employee Benefits & Payroll Taxes			588,690	588,690	1,621	590,311		590,311			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,191	4,191		4,191	(1,659)	2,532			24
25	Other Admin. Staff Transportation			1,961	1,961		1,961	314	2,275			25
26	Insurance-Prop.Liab.Malpractice			305,760	305,760		305,760	651	306,411			26
27	Other (specify):*							45,075	45,075			27
28	TOTAL General Administration	353,031	37,927	1,849,198	2,240,156	1,621	2,241,777	(467,355)	1,774,422			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,827,085	858,145	2,623,082	7,308,312		7,308,312	(535,564)	6,772,748			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number California Gardens N & R

#0040022

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			113,866	113,866		113,866	(15,694)	98,172			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,061	48,061		48,061	970,087	1,018,148			32
33	Real Estate Taxes			410,899	410,899		410,899		410,899			33
34	Rent-Facility & Grounds			1,779,818	1,779,818		1,779,818	(1,764,832)	14,986			34
35	Rent-Equipment & Vehicles			13,139	13,139		13,139	9,596	22,735			35
36	Other (specify):*											36
37	TOTAL Ownership			2,365,783	2,365,783		2,365,783	(800,843)	1,564,940			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	15,308	152,252	57,393	224,953		224,953	(93)	224,860			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,417	160,417		160,417		160,417			42
43	Other (specify):*	26,788			26,788		26,788	(26,788)				43
44	TOTAL Special Cost Centers	42,096	152,252	217,810	412,158		412,158	(26,881)	385,277			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,869,181	1,010,397	5,206,675	10,086,253		10,086,253	(1,363,288)	8,722,965			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R

0040022

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,487)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(134)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,241)	21		18
19	Entertainment	(2,593)	24		19
20	Contributions	(13,393)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(119,787)	21		24
25	Fund Raising, Advertising and Promotional	(14,850)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,046)	20		28
29	Other-Attach Schedule	(132,744)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (307,275)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(1,056,013)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,056,013)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,363,288)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
California Gardens N & R			
Report Period Beginning:	10/01/02		
Ending:	12/31/02		
NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1 VA Pharmacy	\$ (56,425)	10	1
2 VA Medical Expenses	(11,196)	10	2
3 VA Concentrators	(142)	10	3
4 Bank Charges	(26,161)	21	4
5 Capitalized R&M	(1,962)	40	5
6 R/L TC Cope Dues	(4,601)	20	6
7 Annual Report Fees	(125)	20	7
8 Patient Needs	(1,364)	19	8
9 Nonallowable Legal Fees	(3,079)	19	9
10 Bank Charges	(322)	21	10
11 Marketing Salaries	(26,780)	43	11
12 Marketing Professional Fees	(843)	15	12
13			13
14			14
15			15
16			16
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92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(132,744)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number California Gardens N & R

0040022

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(134)											(134)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			491									491	5
6	Maintenance	(1,963)		2,243									280	6
7	Other (specify):*			(41)									(41)	7
8	TOTAL General Services	(2,097)		2,693									596	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(69,061)		227									(68,834)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			3									3	14
15	Other (specify):*			26									26	15
16	TOTAL Health Care and Programs	(69,061)		256									(68,805)	16
	C. General Administration													
17	Administrative			(568,819)	66,220	(2,231)							(504,830)	17
18	Directors Fees													18
19	Professional Services	(3,923)		1,844		51							(2,028)	19
20	Fees, Subscriptions & Promotions	(33,815)		1,649		(97)							(32,263)	20
21	Clerical & General Office Expenses	(149,511)		176,172		724							27,385	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,593)		911		23							(1,659)	24
25	Other Admin. Staff Transportation			314									314	25
26	Insurance-Prop.Liab.Malpractice			651									651	26
27	Other (specify):*			38,527	4,859	1,689							45,075	27
28	TOTAL General Administration	(189,842)		(348,751)	71,079	159							(467,355)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(261,000)		(345,802)	71,079	159							(535,564)	29

Summary B

Facility Name & ID Number	California Gardens N & R	#	0040022	Report Period Beginning:	01/01/03	Ending:	12/31/03
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
30	Depreciation	(19,487)		3,793									(15,694)
31	Amortization of Pre-Op. & Org.												30
32	Interest		971,118	(1,023)		(8)							31
33	Real Estate Taxes												32
34	Rent-Facility & Grounds		(1,779,818)	14,986									33
35	Rent-Equipment & Vehicles			9,596									34
36	Other (specify):*												35
37	TOTAL Ownership	(19,487)	(808,700)	27,352		(8)							36
	Ancillary Expense												37
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers			(93)									39
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(26,788)											43
44	TOTAL Special Cost Centers	(26,788)		(93)									44
45	GRAND TOTAL COST												
	(sum of lines 29, 37 & 44)	(307,275)	(808,700)	(318,543)	71,079	151							(1,363,288)

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent	\$ 1,779,818	California Associates	100.00%	\$	\$ (1,779,818)
2	V	32 Interest		California Associates	100.00%	\$ 820,178	\$ 971,118
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,779,818			\$ 820,178	\$ * (808,700)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R

0040022

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	NUCARE SERVICES CORP.	100.00%	\$ 491	\$ 491
16	V	6 REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	2,243	2,243
17	V	7 EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.	100.00%	(41)	(41)
18	V	10 NURSING ADMIN.		NUCARE SERVICES CORP.	100.00%	227	227
19	V	14 PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	3	3
20	V	15 HEALTHCARE EMPLOYEE BEN.		NUCARE SERVICES CORP.	100.00%	26	26
21	V	17 ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.	100.00%	29,362	29,362
22	V	19 PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	1,844	1,844
23	V	20 FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,649	1,649
24	V	21 CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	176,172	176,172
25	V	24 SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	911	911
26	V	25 ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	314	314
27	V	26 INSURANCE		NUCARE SERVICES CORP.	100.00%	651	651
28	V	27 EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	38,527	38,527
29	V	30 DEPRECIATION		NUCARE SERVICES CORP.	100.00%	3,793	3,793
30	V	32 INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	(1,023)	(1,023)
31	V	34 BUILDING RENT		NUCARE SERVICES CORP.	100.00%	14,986	14,986
32	V	35 EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	9,596	9,596
33	V	39 ANCILLARY		NUCARE SERVICES CORP.	100.00%	(93)	(93)
34	V						
35	V	17 MANAGEMENT FEES	598,181	NUCARE SERVICES CORP.	100.00%		(598,181)
36	V						
37	V						
38	V						
39	Total		\$ 598,181			\$ 279,638	\$ * (318,543)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R

0040022

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMIN. - R. HARTMAN	\$	NUCARE SERVICES CORP.	100.00%	\$ 25,493	\$ 25,493
16	V	17 ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	20,929	20,929
17	V	17 ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	5,586	5,586
18	V	17 ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%	14,212	14,212
19	V						
20	V	27 EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	2,258	2,258
21	V	27 EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	997	997
22	V	27 EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	436	436
23	V	27 EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%	1,168	1,168
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 71,079	\$ * 71,079

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 7,744	\$ 7,744
16	V	19 PROFESSIONAL FEES				51	51
17	V	20 FEES, SUBSCRIPTIONS				(97)	(97)
18	V	21 CLERICAL AND GENERAL				724	724
19	V	24 SEMINARS				23	23
20	V	27 GEN ADMIN.- EMP. BEN.				1,689	1,689
21	V	32 INTEREST EXPENSE				(8)	(8)
22	V						
23	V						
24	V	17 MANAGEMENT FEES	9,975				(9,975)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,975			\$ 10,126	\$ * 151

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R

0040022

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee Benefits	\$ 59,957	DIAMOND INSURANCE	25.00%	\$ 59,957	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 59,957			\$ 59,957	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R # 0040022 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	57.48%	See Attached	5.06	10.12%	Allocated	\$ 25,493	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See Attached	5.52	9.20%	Allocated	20,929	17-7	2
3	David Hartman	Relative	Administrative	None	See Attached	1.10	2.29%	Allocated	5,586	17-7	3
4	Eitan Dickman	Relative	Administrator	None	See Attached	13.81	31.87%	Alloc/Salary	102,484	17-1, 7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 154,492		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R # 0040022 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization NUCARE SERVICES CORP.
 Street Address 6677 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	AVAIL. CENSUS DAYS	755,108	9	\$ 3,469	\$	106,945	\$ 491	1
2	6 REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	755,108	9	15,840	(985)	106,945	2,243	2
3	7 EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	755,108	9	(289)		106,945	(41)	3
4	10 NURSING ADMIN.	AVAIL. CENSUS DAYS	755,108	9	1,600	1,600	106,945	227	4
5	14 PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	755,108	9	19		106,945	3	5
6	15 HEALTHCARE EMPLOYEE BEN.	AVAIL. CENSUS DAYS	755,108	9	180		106,945	25	6
7	17 ADMINISTRATIVE - NON-OWNED	AVAIL. CENSUS DAYS	755,108	9	207,317	202,582	106,945	29,362	7
8	19 PROFESSIONAL FEES	AVAIL. CENSUS DAYS	755,108	9	13,022		106,945	1,844	8
9	20 FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	755,108	9	11,642		106,945	1,649	9
10	21 CLERICAL & GENERAL	AVAIL. CENSUS DAYS	755,108	9	1,243,897	1,034,436	106,945	176,172	10
11	24 SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	755,108	9	6,435		106,945	911	11
12	25 ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	755,108	9	2,216		106,945	314	12
13	26 INSURANCE	AVAIL. CENSUS DAYS	755,108	9	4,598		106,945	651	13
14	27 EMPLOYEE BEN. GEN. ADMIN.	AVAIL. CENSUS DAYS	755,108	9	272,029		106,945	38,527	14
15	30 DEPRECIATION	AVAIL. CENSUS DAYS	755,108	9	26,781		106,945	3,793	15
16	32 INTEREST EXPENSE	AVAIL. CENSUS DAYS	755,108	9	(7,220)		106,945	(1,023)	16
17	34 BUILDING RENT	AVAIL. CENSUS DAYS	755,108	9	105,808		106,945	14,986	17
18	35 EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	755,108	9	67,754		106,945	9,596	18
19	39 ANCILLARY	AVAIL. CENSUS DAYS	755,108	9	(652)	(1,593)	106,945	(92)	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,974,446	\$ 1,236,040		\$ 279,638	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization NUCARE SERVICES CORP.
 Street Address 6677 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36	9	180,000	180,000	5	25,493	1
2	17 ADMIN. - B. CARR	AVG. HOURS WORKED	48	9	180,000	180,000	6	20,929	2
3	17 ADMIN. - D. HARTMAN	AVG. HOURS WORKED	8	9	40,623	40,000	1	5,586	3
4	17 ADMIN. - E. DICKMAN	AVG. HOURS WORKED	17	9	17,157	17,000	14	14,212	4
5									5
6	27 EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36	9	15,944		5	2,258	6
7	27 EMP. BEN. - B. CARR	AVG. HOURS WORKED	48	9	8,574		6	997	7
8	27 EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	8	9	3,170		1	436	8
9	27 EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	17	9	1,411		14	1,168	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 446,879	\$ 417,000		\$ 71,079	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022 Report Period Beginning:01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CAREPATH HEALTH NETWORKStreet Address 6633 N LINCOLN AVENUECity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number (888) 707-6700Fax Number (847) 679-2150

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMINISTRATIVE	CARE PATH FEES	339,037	13	\$ 263,221	\$ 263,221	9,975	\$ 7,744	1
2	19 PROFESSIONAL FEES	CARE PATH FEES	339,037	13	1,730		9,975	51	2
3	20 FEES, SUBSCRIPTIONS	CARE PATH FEES	339,037	13	(3,296)		9,975	(97)	3
4	21 CLERICAL AND GENERAL	CARE PATH FEES	339,037	13	24,604		9,975	724	4
5	24 SEMINARS	CARE PATH FEES	339,037	13	784		9,975	23	5
6	27 GEN ADMIN.- EMP. BEN.	CARE PATH FEES	339,037	13	57,412		9,975	1,689	6
7	32 INTEREST EXPENSE	CARE PATH FEES	339,037	13	(286)		9,975	(8)	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 344,169	\$ 263,221		\$ 10,126	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DIAMOND INSURANCE
 Street Address 40 SKOKIE BLVD, SUITE 105
 City / State / Zip Code NORTHBROOK, IL 60062
 Phone Number (847) 559-1002
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	DIAMOND INSURANCE	DIRECT ALLOC.		\$	\$		\$ 59,957	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 59,957	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R # 0040022 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R# 0040022 Report Period Beginning:01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R # 0040022 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Shareholder Loan	x		Working Capital	Interest Only			2,500,000		Prime+1	48,061	6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related						\$	\$ 2,500,000			\$ 48,061	9	
	B. Non-Facility Related*												
10												10	
11	Alloc-NuCare Services Corp		x								(1,031)	11	
12	California Gardens Assoc		x								97,118	12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ 96,087	14	
15	TOTALS (line 9+line14)						\$	\$ 2,500,000			\$ 144,148	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$		
1. Real Estate Tax accrual used on 2002 report.		\$	421,750	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	406,170	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(15,580)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	426,479	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	410,899	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	367,798	8	
	1999	360,947	9	
	2000	391,485	10	
	2001	401,667	11	
	2002	406,170	12	
Accrual - 406,170 x 1.05 = 426479				

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME California Gardens N & R COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040022

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-25-401-015-0000</u>	<u>Long Term Care</u>	\$ <u>406,170.00</u>	\$ <u>406,170.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>406,170.00</u>	\$ <u>406,170.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME California Gardens N & R COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040022

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

72,844

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

4

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	193,025	1987	\$ 300,000	1
2					2
3	TOTALS	193,025		\$ 300,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XL OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	Various	1981	4,471		20	-		205	9
10	Various	1982	2,319		20	-		222	10
11	Various	1983	10,829		20	497	497	1,580	11
12	Various	1984	1,410		20	71	(71)	212	12
13	Various	1985	17,805		20	100	100	300	13
14	Various	1986	22,863		20	1,143	1,143	3,429	14
15	Various	1987	40,100		20	2,005	2,005	6,015	15
16	Various	1988	2,787		20	139	139	2,102	16
17	Various	1989	3,024		20	151	151	453	17
18	Various	1990	8,652		20	433	433	1,298	18
19	Various	1991	3,892		20	195	195	584	19
20	Various	1993	24,138		20	1,207	1,207	3,621	20
21	Various	1994	8,195		20	410	410	1,230	21
22	Various	1995	17,230		20	863	863	7,463	22
23	Various	1996	46,848		20	2,342	2,342	17,096	23
24	Various	1997	70,702		20	3,591	3,591	23,610	24
25	Various	1998	33,854		20	1,695	1,695	9,389	25
26	Various	1999	104,536		20	5,227	5,227	23,399	26
27						-		-	27
28						-		-	28
29						-		-	29
30						-		-	30
31						-		-	31
32						-		-	32
33						-		-	33
34						-		-	34
35						-		-	35
36						-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		4,708,760						67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		3,374	136		170	34	758	68
69	Financial Statement Depreciation			50,247			(50,247)		69
70	TOTAL (lines 4 thru 69)		\$ 5,135,789	\$ 50,383		\$ 20,239	\$ (30,286)	\$ 102,966	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,135,789	\$ 50,383		\$ 20,239	\$ (30,144)	\$ 102,966	1
2	Inst.6 New Drain Out	2000	900		20	45	45	180	2
3	Inst 3 Windows/1St F	2000	4,475		20	224	224	896	3
4	First Floor Renovati	2000	33,510		20	1,676	1,676	6,563	4
5	First Floor Renovati	2000	7,990		20	400	400	1,566	5
6	42 Engraved Signs	2000	1,912		20	96	96	375	6
7	Wall Covering	2000	19,422		20	971	971	3,803	7
8	Ceiling Tiles	2000	1,076		20	54	54	212	8
9	Over Bed Lights	2000	5,563		20	278	278	1,066	9
10	Install Over Bed Lig	2000	5,775		20	289	289	1,108	10
11	Overbed Lights-Insta	2000	5,933		20	297	297	1,113	11
12	Cubicle Curtains	2000	19,813		20	991	991	3,715	12
13	Red Oak Wood Door	2000	601		20	30	30	113	13
14	Labor For Install 1S	2000	460		20	23	23	86	14
15	Tank Rental	2000	2,500		20	125	125	469	15
16	Draperies	2000	2,012		20	101	101	369	16
17	Cabeling For Cctv	2000	956		20	48	48	180	17
18	Install Cctv System	2000	1,991		20	100	100	366	18
19	Handrails,Mounting B	2000	9,909		20	495	495	1,940	19
20	Freight For Handrail	2000	210		20	11	11	42	20
21	Install Window Treat	2000	1,134		20	57	57	189	21
22	Mini Blinds	2000	110		20	6	6	19	22
23	Shipping-Draperies	2000	117		20	6	6	22	23
24	Drapery	2000	729		20	36	36	130	24
25	6 Magnetek Motors	2000	538		20	27	27	97	25
26	Furn & Test Lights	2000	490		20	25	25	87	26
27	Wall Covering	2000	4,568		20	228	228	780	27
28	Installed Cctv Syste	2000	1,447		20	72	72	271	28
29	Service Fire Door	2000	821		20	41	41	154	29
30	Elec Cables To Kitch	2000	626		20	31	31	117	30
31	Install Alarm System	2000	631		20	32	32	119	31
32	Telephone Serv/3 Pha	2000	375		20	19	19	71	32
33	Ran Tel Line To Base	2000	717		20	36	36	132	33
34	TOTAL (lines 1 thru 33)		\$ 5,273,100	\$ 50,383		\$ 27,109	\$ (23,274)	\$ 129,316	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,273,100	\$ 50,383		\$ 27,109	\$ (23,274)	\$ 129,316	1
2	Ran Line To Acctg Of	2000	978		20	49	49	176	2
3	Landcaping Serv	2000	2,050		20	103	103	351	3
4	Chair Rail & Wall Gu	2000	2,964		20	148	148	506	4
5	Border	2000	265		20	13	13	44	5
6	Fan Coils For A/C Un	2000	516		20	26	26	87	6
7	Landcaping	2000	625		20	31	31	102	7
8	Window & Door Glass	2000	4,900		20	245	245	939	8
9	Inst Wanderguard Sys	2000	26,630		20	1,332	1,332	5,216	9
10	Tree Removal	2000	690		20	35	35	110	10
11	Wall Guards	2000	1,982		20	99	99	314	11
12	Kick Plates	2000	2,948		20	147	147	467	12
13	Wallpaper	2000	894		20	45	45	142	13
14	Fire Alarm Repairs	2000	1,117		20	56	56	177	14
15	First Flr Ren	2000	7,710		20	386	386	1,511	15
16	Nurses Station Cou	2000	3,020		20	151	151	453	16
17	Water Heater	2001	8,920		20	446	446	1,338	17
18	Run Cbl To Fire Alrm	2001	790		20	40	40	119	18
19	Telephone Line, Inst	2001	807		20	40	40	121	19
20	Reple Car Sill On #2	2001	1,580		20	79	79	230	20
21	Moved One Heater W/A	2001	750		20	38	38	113	21
22	Wander Guard Devices	2001	686		20	34	34	97	22
23	72 Ovrbed Light 3' B	2001	5,332		20	267	267	756	23
24	Epr Fire Pump Repair	2001	575		20	29	29	77	24
25	Window Treatment Dr	2001	1,815		20	91	91	250	25
26	Wallcovering Corrido	2001	6,924		20	346	346	923	26
27	Electomagnet Holder	2001	494		20	25	25	66	27
28	Ccd Dome Camera W/Wi	2001	1,621		20	81	81	216	28
29	Door Latch & Lock Se	2001	654		20	33	33	84	29
30	Wallguards	2001	4,840		20	242	242	645	30
31	Vinyl Cove Base	2001	141		20	7	7	19	31
32	Wallpaer & Over Be	2001	6,212		20	311	311	828	32
33	Installed Concrete F	2001	11,400		20	570	570	1,330	33
34	TOTAL (lines 1 thru 33)		\$ 5,383,930	\$ 50,383		\$ 32,654	\$ (17,729)	\$ 147,123	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,383,930	\$ 50,383		\$ 32,654	\$ (17,729)	\$ 147,123	1
2	Service On Nurses Ca	2001	926		20	46	46	120	2
3	Service On Electroma	2001	1,037		20	52	52	134	3
4	Ran Phone Lines	2001	699		20	35	35	90	4
5	Installed Cctv Monit	2001	1,391		20	70	70	180	5
6	Ceiling Tile	2001	673		20	34	34	76	6
7	Installed Cctv Monit	2001	1,440		20	72	72	162	7
8	Service On Nurses Ca	2001	830		20	42	42	94	8
9	Srvc On Bsmnt P.A Sv	2001	983		20	49	49	110	9
10	Installed Cctv Mntr	2001	1,724		20	86	86	186	10
11	Srvc On Exit Door Al	2001	872		20	44	44	94	11
12	New Foundation Wall	2001	1,500		20	75	75	156	12
13	Ceiling Tile	2001	499		20	25	25	52	13
14	Ceiling Tile	2001	461		20	23	23	48	14
15	Ceiling Tile	2001	461		20	23	23	48	15
16	Installed Cctv Mntr	2001	1,376		20	69	69	150	16
17	Electrical Wrk On Ou	2001	1,157		20	58	58	121	17
18	Phone Line Install	2002	6,351		20	635	635	1,270	18
19	Boiler	2002	4,779		20	478	478	876	19
20	Canopy	2002	1,817		20	182	182	318	20
21	Wanderguard System	2002	1,973		20	197	197	329	21
22	Phone Line Install	2002	5,446		20	545	545	953	22
23	Resurface Lot/Sidewalk	2002	25,274		20	1,685	1,685	2,247	23
24	Exit Sign	2002	1,275		20	128	128	170	24
25	Phone Line Install	2002	1,868		20	187	187	234	25
26	Fire Pump	2002	2,730		20	273	273	341	26
27	Sign Fixture	2003	987		20	82	82	82	27
28	Loc System	2003	1,338		20	191	191	191	28
29	Cat5 Run	2003	1,025		20	98	98	98	29
30	Cctv System	2003	1,516		20	217	217	217	30
31	Telephone Lines	2003	907		20	91	91	91	31
32	Telephone Lines	2003	860		20	86	86	86	32
33	Cctv Monitors	2003	1,151		20	164	164	164	33
34	TOTAL (lines 1 thru 33)		\$ 5,459,256	\$ 50,383		\$ 38,696	\$ (11,687)	\$ 156,611	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 5,459,256	\$ 50,383		\$ 38,696	\$ (11,687)	\$ 156,611	1
2	Monitoring System	2003	2,908		20	415	415	415	2
3	Lanscaping	2003	23,600		20	1,573	1,573	1,573	3
4	Landscaping	2003	590		20	39	39	39	4
5	Landscaping	2003	400		20	27	27	27	5
6	Repair Elevator	2003	1,054		20	22	22	22	6
7	Repair Elevator	2003	1,878		20	39	39	39	7
8	Door Alarm	2003	1,228		20	58	58	58	8
9	Cctv To Monitor	2003	1,079		20	51	51	51	9
10	Dr Alarm	2003	1,147		20	41	41	41	10
11	Sprinkler Heads	2003	1,000		20	17	17	17	11
12	Repair Elevator	2003	5,236		20	44	44	44	12
13	Cctv To Monitor	2003	4,660		20	111	111	111	13
14	Exterior Lights	2003	877		20	15	15	15	14
15	Elevator Repairs	2003	507		20				15
16	Elevator Repairs	2003	717		20				16
17	Fire Alarm Repairs	2003	739		20				17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
Constructed			Depreciation	in Years	Depreciation		Depreciation	
1	Totals from Page 12F, Carried Forward	\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	34

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,506,876	\$ 50,383		\$ 41,148	\$ (9,235)	\$ 159,063	34

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation
4			1977	1977	\$ 4,708,760	\$		\$	\$	\$
5										
6										
7										
8										
9	Improvement Type**									
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
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25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,708,760	\$		\$	\$	\$	70

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Allocated from NuCare Services Corp			1997	652	17	20	33	16	203	9	
10	Allocated from NuCare Services Corp			1998	571	15	20	29	14	156	10	
11	Allocated from NuCare Services Corp			1999	801	69	20	40	(29)	178	11	
12	Allocated from NuCare Services Corp			2000	973	25	20	49	(24)	167	12	
13	Allocated from NuCare Services Corp			2001	377	10	20	19	9	54	13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*Total beds on this schedule must agree with page 2.
 See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,374	\$ 136		\$ 170	\$ (14)	\$ 758	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 484,862	\$ 58,145	\$ 51,679	\$ (6,466)	10	\$ 234,475	71
72	Current Year Purchases	57,810	7,179	5,168	(2,011)	10	5,168	72
73	Fully Depreciated Assets	51,077	178	178		10	51,077	73
74								74
75	TOTALS	\$ 593,749	\$ 65,502	\$ 57,025	\$ (8,477)		\$ 290,720	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 FORD WAGON	1997	\$ 21,161	\$ 1,775	\$	\$ (1,775)	5	\$ 21,160	76
77										77
78										78
79										79
80	TOTALS			\$ 21,161	\$ 1,775	\$	\$ (1,775)		\$ 21,160	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,421,786	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,660	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 98,173	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,487)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 470,943	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NuVision Holding, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			<u>7/1/94</u>	\$ <u>1,779,818</u>			3
4	Additions							4
5	Alloc	<u>California Assoc</u>			<u>(1,779,818)</u>			5
6	Alloc-NuCare Services Corp				<u>14,986</u>			6
7	TOTAL				\$ <u>14,986</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 22,207 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>1999 Infiniti</u>	\$ <u>486.00</u>	\$ <u>528</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>486.00</u>	\$ <u>528</u>	21

10. Effective dates of current rental agreement:

Beginning 7/1/94

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ 1,584,360

13. /2005 \$ 1,584,360

14. /2006 \$ 1,584,360

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input checked="" type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>120</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	1,050	\$	1,050
2	Books and Supplies		505		505
3	Classroom Wages (a)				
4	Clinical Wages (b)		3,895		3,895
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	5,450	\$	5,450
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,450		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 28,696	\$		\$ 28,696	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,018			4,018	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			24,679			24,679	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				102,815		102,815	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify): See Supplemental			15,308			49,437		64,745	13
14	TOTAL			\$ 15,308		\$ 57,393	\$ 152,252		\$ 224,953	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits		1,152	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)		2,600,197	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		184,692	6
7	Other Prepaid Expenses		20,526	7
8	Accounts Receivable (owners or related parties)		205,558	8
9	Other(specify): See Attached Schedule		207,807	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	3,219,932	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		639,281	15
16	Equipment, at Historical Cost		577,759	16
17	Accumulated Depreciation (book methods)		(673,499)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		76,913	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	620,454	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	3,840,386	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	623,345	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		2,500,000	29
30	Accrued Salaries Payable		231,587	30
31	Accrued Taxes Payable (excluding real estate taxes)		7,265	31
32	Accrued Real Estate Taxes(Sch.IX-B)		426,479	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		9,880	35
	Other Current Liabilities(specify):			
36	See Attached Schedule		221,633	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	4,020,189	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$		45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	4,020,189	46
47	TOTAL EQUITY(page 18, line 24)	\$	(179,803)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	3,840,386	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 137,275	1
2	Restatements (describe):		2
3	Expense Restatement	(140,310)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,035)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(176,768)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (176,768)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (179,803)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,753,872	1
2	Discounts and Allowances for all Levels	(157,883)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,595,989	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	102,741	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 102,741	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	171,891	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,463	19
20	Radiology and X-Ray	560	20
21	Other Medical Services	24,841	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 210,755	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,909,485	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,783,241	31
32	Health Care	3,284,915	32
33	General Administration	2,240,156	33
	B. Capital Expense		
34	Ownership	2,365,783	34
	C. Ancillary Expense		
35	Special Cost Centers	251,741	35
36	Provider Participation Fee	160,417	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,086,253	40
41	Income before Income Taxes (line 30 minus line 40)**	(176,768)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (176,768)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number California Gardens N & R# 0040022Report Period Beginning: 01/01/03Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,679	2,000	\$ 81,335	\$ 40.67	1
2	Assistant Director of Nursing	301	514	14,094	27.42	2
3	Registered Nurses	28,068	30,222	726,995	24.06	3
4	Licensed Practical Nurses	39,117	41,818	770,313	18.42	4
5	Nurse Aides & Orderlies	105,233	113,002	1,017,983	9.01	5
6	Nurse Aide Trainees	600	600	3,895	6.49	6
7	Licensed Therapist	406	436	15,308	35.11	7
8	Rehab/Therapy Aides	5,657	6,274	54,709	8.72	8
9	Activity Director	3,409	3,670	37,186	10.13	9
10	Activity Assistants	7,692	8,358	64,290	7.69	10
11	Social Service Workers	8,279	10,683	81,806	7.66	11
12	Dietician	3,890	4,411	84,609	19.18	12
13	Food Service Supervisor					13
14	Head Cook	9,752	10,858	115,570	10.64	14
15	Cook Helpers/Assistants	17,153	18,991	137,392	7.23	15
16	Dishwashers					16
17	Maintenance Workers	8,430	9,444	148,870	15.76	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	3,509	3,626	223,367	61.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,077	3,123	129,664	41.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,135	6,541	76,310	11.67	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,367	4,796	58,697	12.24	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,037	1,119	26,788	23.94	33
34	TOTAL (lines 1 - 33)	259,791	280,486	\$ 3,869,181 *	\$ 13.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 11,640	01-03	35
36	Medical Director	Monthly	33,300	09-03	36
37	Medical Records Consultant	Monthly	2,708	10-03	37
38	Nurse Consultant	13	405	10-03	38
39	Pharmacist Consultant	Monthly	5,928	10-03	39
40	Physical Therapy Consultant	73	3,632	10a-03	40
41	Occupational Therapy Consultant	144	7,763	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	3,193	11-03	44
45	Social Service Consultant	54	2,858	12-03	45
46	Other(specify)				46
47	<u>DD Therapy Consultant</u>	83	5,303	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	426	\$ 76,730		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 800	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	16	\$ 800		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R

0040022

Report Period Beginning: 01/01/03

Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rick Walworth-from 4/03	Administrator	None	\$ 81,519	Workers' Compensation Insurance	\$ 59,957	IDPH License Fee	\$	
Eitan Dickman-through 4/03	Administrator	None	88,273	Unemployment Compensation Insurance	64,169	Advertising: Employee Recruitment	8,229	
Ray Dolan	VP Risk Mgmt	None	5,045	FICA Taxes	273,195	Health Care Worker Background Check (Indicate # of checks performed _____)		
Rusti Bauman	VP Medicare Reimb	None	2,095	Employee Health Insurance	78,347	Advertising Expense	14,084	
Marilyn Flaherty	VP Medicare Reimb	None	2,787	Employee Meals	1,621	Dues ICLTC	12,169	
Farat Shariff	VP of Operations	None	28,332	Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	537	
Kathy Brander	Dir. Reg Management	None	15,317	Union Health Insurance	55,698	Licenses and Fees	3,013	
TOTAL (agree to Schedule V, line 17, col. 1)				Union Pension Benefits	27,800	Alloc-Carepath	(97)	
(List each licensed administrator separately.)			\$ 223,368	Employee Benefits	21,682	See Supplemental Schedule	1,649	
B. Administrative - Other				Life Insurance Expense	5,182	Less: Public Relations Expense (
Description			Amount	401K Matching Expense	2,660	Non-allowable advertising	(13,038)	
Management Fees - NuCare Services Corp			\$ 598,181			Yellow page advertising	(1,046)	
Management Fees - Carepath			9,975					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 608,156	TOTAL (agree to Schedule V, line 22, col.8)	\$ 590,311	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,500	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
FR&R	Accounting		\$ 24,683				Out-of-State Travel	\$
Dan Foley, CPA	Accounting		200					
CDW Computer Centers	Computer Services		1,267					
Giftrap	Computer Services		5,458				In-State Travel	
HDSI	Computer Services		5,346					
IVANS	Computer Services		549					
Medi-Com	Computer Services		1,546					
PSD	Computer Services		9,037				Seminar Expense	1,598
Personnel Planners	Unemployment Consulting		4,899				Alloc - Carepath	23
Purchasing Plus	Purchasing Services		600				Alloc - NuCare Services Corp	911
See Supplemental Schedule			25,825				Entertainment Expense (
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 79,410				TOTAL	\$ 2,532

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number California Gardens N & R

STATE OF ILLINOIS

0040022

Report Period Beginning:

01/01/03

Ending:

Page 23

12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$12,169
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,955 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
California Gardens Nursing Center #00040022, 7/1/1994
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 160,417
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,621 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.